

## Consent for Evaluation and Treatment

Please take your time to read and review the information included below. It is important that you completely understand all the points to avoid any misunderstandings about the practice policies. Please ask questions if you are not sure about any portion of this form, information on the website, or specifics about any of the services. You have the right to ask questions and understand all the information on this form and website before starting any service.

Any information that you disclose will be maintained in the strictest confidence, unless you specifically authorize its release, or unless its release is required by law or professional standards of practice. In particular, your right to confidentiality may not be maintained if you are in immediate danger to yourself or to someone else, which may warrant steps to assure your own and/or another's safety. Any clinician hearing about domestic violence from a client or that a child or elder is being or has been physically or psychologically abused is required, by law, to report this information to a designated agency. If it is deemed necessary to disclose information, information that you have provided in the course of treatment, to anyone else, this will be discussed with you.

All outpatient visits must be paid prior to the start of the appointment. If your insurance carrier is accepted, claims will be submitted to the insurance carrier; otherwise, at the end of the month, you will be provided with an insurance statement to submit to your insurance company (available upon request). I do not accept responsibility for negotiating claims with insurance companies or other personnel. You are responsible for payment regardless of the reimbursement eligibility of your claim. Any other financial arrangement must be made prior to service.

**Appointments can be rescheduled or cancelled with advanced notice of a minimum of one business day (24 hours). Cancellations for Monday appointments need to be left on voicemail by the preceding Friday, before 1:00 pm. However, if you do not provide a one business day notice, you agree to pay for the entire cost of the visit. Please call 805-284-1783 to leave a message if you need to cancel your appointment.**

**Telephone Crisis Intervention/Counseling: \$25.00 for every 15 minutes.**

If payment is not received 60 days after the date of service, your account may be sent to a collection agency. By signing this form, you further agree to cover all court costs and legal expenses associated with resolving any unpaid charges. Under circumstances where a party other than the client is responsible for payment, that party must sign a separate agreement guaranteeing payment of the bill as well as payment for any legal expenses associated with collecting for any unpaid charges.

If you are not able to pay, and still require services, you will be offered assistance to help you connect with affordable community resources. For returned checks, you agree to be billed for the total amount due plus the total bank penalty fees.

If you plan to use insurance, you give consent to have your evaluation and treatment information disclosed to your insurance provider(s) for purposes of collecting payment. You also agree to pay the full of amount of the fees if your insurance carrier determines that you are not eligible for services.

**PLEASE CHECK WITH YOUR INSURANCE PROVIDER(S) TO MAKE SURE THAT YOU ARE ELIGIBLE FOR SERVICES PROVIDED BY Dr. Alfredo Bimbela TO AVOID UNPLANNED EXPENSES.**

I have read and understood the foregoing as well as the information posted on the website. I consent to evaluation and treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_